Do Not Photocopy; Information on Both Sides

HIRSP Prescription Drug Claim

POLICYHOLDER INFORMATION

Please PRINT

POLICYHOLDER NAME (Last Name, First Name)	POLICYHOLDER I.D. NO.	GROUP NO.	PLAN CODE
			950

IF THIS CLAIM IS FOR COORDINATION OF BENEFITS (COB), PLEASE CHECK THIS BOX. ☐ **SEE INSTRUCTIONS ON BACK**

DOES POLICYHOLDER HAVE OTHER DRUG COVERAGE	POLICYHOLDER'S GENDER	POLICYHOLDER DATE OF BIRTH MO	DAY	YEAR
☐ YES ☐ NO	☐ MALE ☐ FEMALE			

MAILING ADDRESS OF POLICYHOLDER (Number and Street)	PLEASE CHECK IF NEW ADDRESS ☐ (See instructions on back)	CITY	STATE	ZIP CODE

I CERTIFY THAT THE POLICYHOLDER FOR WHOM THIS CLAIM IS MADE IS A COVERED PERSON IN THIS PROGRAM AND THAT THE PRESCRIPTION IS FOR THE SOLE USE OF THE NAMED POLICYHOLDER. I ALSO CERTIFY THAT THE CLAIM(S) BEING SUBMITTED FOR PAYMENT ARE NOT ELIGIBLE FOR PAYMENT UNDER A NO-FAULT AUTOMOBILE OR WORKER'S COMPENSATION INSURANCE PROGRAM.

(Policyholder/Authorized Representative) X _____ (Date) _____

PRESCRIPTION INFORMATION

CLAIM NUMBER	FOR OFFICE USE ONLY	Rx NUMBER	DATE Rx FILLED	NEW	REFILL	NAME OF DRUG/STRENGTH/DOSAGE FORM (If generic include manufacturer, if Compounded Rx complete reverse side.)
1				☐	☐	

NDC	QUANTITY	DAYS SUPPLY	NAME OF PRESCRIBING PHYSICIAN	PATIENT PAID PHARMACY
				$

DIAGNOSIS	PHARMACY # (aka NCPDP/NABP #)	NAME AND ADDRESS OF PHARMACY	

CLAIM NUMBER	FOR OFFICE USE ONLY	Rx NUMBER	DATE Rx FILLED	NEW	REFILL	NAME OF DRUG/STRENGTH/DOSAGE FORM (If generic include manufacturer, if Compounded Rx complete reverse side.)
2				☐	☐	

NDC	QUANTITY	DAYS SUPPLY	NAME OF PRESCRIBING PHYSICIAN	PATIENT PAID PHARMACY
				$

DIAGNOSIS	PHARMACY # (aka NCPDP/NABP #)	NAME AND ADDRESS OF PHARMACY	

CLAIM NUMBER	FOR OFFICE USE ONLY	Rx NUMBER	DATE Rx FILLED	NEW	REFILL	NAME OF DRUG/STRENGTH/DOSAGE FORM (If generic include manufacturer, if Compounded Rx complete reverse side.)
3				☐	☐	

NDC	QUANTITY	DAYS SUPPLY	NAME OF PRESCRIBING PHYSICIAN	PATIENT PAID PHARMACY
				$

DIAGNOSIS	PHARMACY # (aka NCPDP/NABP #)	NAME AND ADDRESS OF PHARMACY	

CLAIM NUMBER	FOR OFFICE USE ONLY	Rx NUMBER	DATE Rx FILLED	NEW	REFILL	NAME OF DRUG/STRENGTH/DOSAGE FORM (If generic include manufacturer, if Compounded Rx complete reverse side.)
4				☐	☐	

NDC	QUANTITY	DAYS SUPPLY	NAME OF PRESCRIBING PHYSICIAN	PATIENT PAID PHARMACY
				$

DIAGNOSIS	PHARMACY # (aka NCPDP/NABP #)	NAME AND ADDRESS OF PHARMACY	

CLAIM NUMBER	FOR OFFICE USE ONLY	Rx NUMBER	DATE Rx FILLED	NEW	REFILL	NAME OF DRUG/STRENGTH/DOSAGE FORM (If generic include manufacturer, if Compounded Rx complete reverse side.)
5				☐	☐	

NDC	QUANTITY	DAYS SUPPLY	NAME OF PRESCRIBING PHYSICIAN	PATIENT PAID PHARMACY
				$

DIAGNOSIS	PHARMACY # (aka NCPDP/NABP #)	NAME AND ADDRESS OF PHARMACY	

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

INSTRUCTIONS

A. WHEN TO USE THIS FORM

This claim form is to be used to obtain reimbursement for a prescription drug that was not submitted on-line by your pharmacist because you did not present your identification card at the time the prescription was filled, or because the pharmacy which filled your prescription was a non-participating pharmacy.

Submit this form as soon as you have your prescription(s) filled in order to receive prompt payment. It IS NOT necessary to retain the form until you have filled in five prescription claims.

B. HOW TO COMPLETE THIS FORM

1. Complete the upper portion of the claim form under POLICYHOLDER information. Transfer the **Policyholder identification number** and **group number** from your identification card or enrollment application.

2. All correspondence and payment will be sent to the address on your ID card. If your address has changed, please contact the Customer Service number on the back of your card.

3. A separate claim form must be completed for each **patient**.

4. Complete the PRESCRIPTION information for each prescription. If you are unable to complete the form from information supplied on the prescription label and/or receipt, ask your pharmacist to complete the form.

5. The **original paid** pharmacy receipt (including the required drug information) MUST accompany this form. Since pharmacy receipts cannot be returned, you may wish to make copies for your records. Personal itemizations, tax statements, cash register tapes, and cancelled checks are not acceptable receipts.

   IMPORTANT: The drug quantity and EITHER the drug name and strength OR National Drug Code is required and **MUST** appear on the submitted claim(s) or receipt(s).

6. For coordination of benefits, an explanation of benefits (EOB) from the other insurance OR a pharmacy statement explaining the other insurance payment must accompany the completed claim form and the pharmacy receipt.

7. **— FOR COMPOUNDED PRESCRIPTIONS ONLY —** If your pharmacist tells you this is a compounded prescription, you must complete the area below. Ask your pharmacist for assistance in listing all ingredients used. Should you have more than two compounded prescriptions, please use additional claim forms.

CLAIM #	COMPOUND INGREDIENTS		
	DRUG NAME	QTY	COST

CLAIM #	COMPOUND INGREDIENTS		
	DRUG NAME	QTY	COST

C. WHERE TO MAIL THIS FORM

Mail this form and your **original paid** pharmacy receipt(s) to:

Prescription Claims
Wisconsin Health Insurance Risk Sharing Plan
6406 Bridge Road, Suite 18
Madison, WI 53784-0018

NOTICE

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any factual material thereto, commits a fraudulent insurance act, which is a crime.